

Registration District No. 605

Primary Registration District No. 4359 5804

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Parma  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None (Specify whether)  
In this community 2 mo. 28 days years, months or days

3. (a) PRINT FULL NAME

C. J. Reynold

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male Color or race White

6. (a) Single, widowed, married, divorced MS

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive 30 years (Month) (Day) (Year)

7. Birth date of deceased April 30 41 (Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

2

28

hr. min.

9. Birthplace

Parma Mo  
(City, town, or county)

State 0  
(State or foreign country)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER {

12. Name Clarence Reynold

13. Birthplace Waller Mo (City, town, or county) (State or foreign country)

14. Maiden name Doris Lambert

15. Birthplace Parma Mo (City, town, or county) (State or foreign country)

16. (a) Informant

Clarence Reynold

(b) Address

Parma Mo

17. (a)

Burial  
(Burial, cremation, or removal)

(b) Date thereof 7-29-41 (Month) (Day) (Year)

(c) Place: burial or cremation

Parma Cemetery

18. (a) Signature of funeral director

Waller

(b) Address

Parma Mo

19. (a)

7-30-41  
(Date received local registrar)

(b) Dr. Geo. W. Husted  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town Parma Mo (If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 28 year 1941 hour 6:00 minute 11 A. M.

21. I hereby certify that I attended the deceased from 7-26-41, 1941, to 7-28-41, 1941; that I last saw him alive on 7-27-41, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death

Colitis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. J. Gilbert (M.D. or other) 0  
Address Parma - Mo Date signed 7/28/41

554

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2,

District File Number 841-1023

Date Filed 8-12-41

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**